For Nursing Facility Use Only:

Last Name:_____ First:_____

Medicaid ID #:_____Date of Birth:____/____/_____

SSN:_____

Date of admission for reimbursement as **Medicaid ONLY**:____/____/____

Does the patient have Third Party Liability (other insurance)?
___Yes (if yes, please fill out section listed below)
___No

Name of Insurance Company_____

Insurance Company Address_____

_____

Insurance Company Phone Number_____

Policy Number_____Group Number_____

Policy Holder Name_____Relationship to Policyholder_____

Effective Date_____

Policy Coverages (check all that apply):

__Hospital Inpatient __Hospital Outpatient __Medical Inpatient

__Medical Outpatient __Pharmacy __SNF __ICF __Ambulance

__Home Health __Major Medical __Medicare Supplement __Other _____
(please indicate)

PLEASE NOTE: This form MUST be submitted to TennCare BEFORE the patient will be enrolled in Choices. In addition, claims will not pay until the patient is enrolled in Choices.

Form must be faxed to the Bureau of TennCare, Choices Enrollment Unit @ 615-253-3179.